LOW OPTION

Principal Benefits for Kaiser Permanente Traditional Plan (1/1/08—12/31/08)

The Services described below are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Southern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage* (*EOC*) for authorized referrals, hospice care, Emergency Care, Post-stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year after the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:	
For self-only enrollment (a Family Unit of one Member)	$1,500 per calendar year
For any one Member in a Family Unit of two or more Members	$1,500 per calendar year
For an entire Family Unit of two or more Members	$3,000 per calendar year
Deductible or Lifetime Maximum	None
Professional Services (Plan Provider office visits)	**You Pay**
Primary and specialty care visits (includes routine and Urgent Care appointments)	$20 per visit
Routine preventive physical exams	$20 per visit
Well-child preventive care visits (0–23 months)	No charge
Family planning visits	$20 per visit
Scheduled prenatal care and first postpartum visit	No charge
Routine preventive refraction exams	$20 per visit
Routine preventive hearing tests	$20 per visit
Physical, occupational, and speech therapy visits	$20 per visit
Outpatient Services	**You Pay**
Outpatient surgery	$20 per procedure
Allergy injection visits	$5 per visit
Allergy testing visits	$20 per visit
Vaccines (immunizations)	No charge
X-rays and lab tests	No charge
Health education:	
Individual visits	$20 per visit
Group educational programs	No charge
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	$250 per admission
Emergency Health Coverage	**You Pay**
Emergency Department visits	$100 per visit (does not apply if admitted directly to the hospital as an inpatient)
Ambulance Services	**You Pay**
Ambulance Services	$50 per trip
Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary guidelines:	
Generic items from a Plan Pharmacy	$10 for up to a 30-day supply, $20 for a 31 to 60-day supply, or $30 for a 61 to 100-day supply
Generic refills from our mail-order program	$20 for up to a 100-day supply
Brand-name items from a Plan Pharmacy	$20 for up to a 30-day supply, $40 for a 31 to 60-day supply, or $60 for a 61 to 100-day supply
Brand-name refills from our mail-order program	$40 for up to 100-day supply
Durable Medical Equipment (DME)	**You Pay**
Most covered DME for home use in accord with our DME formulary guidelines	20% Coinsurance
Mental Health Services	**You Pay**
Inpatient psychiatric care (up to 30 days per calendar year)	$250 per admission

continues

continued

Mental Health Services	You Pay
Outpatient visits:	
Up to a total of 20 individual and group therapy visits per calendar year	$20 per individual therapy visit $10 per group therapy visit
Up to 20 additional group therapy visits that meet the Medical Group criteria in the same calendar year	$10 per group therapy visit
Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *EOC*.	

Chemical Dependency Services	You Pay
Inpatient detoxification	$250 per admission
Outpatient individual therapy visits	$20 per visit
Outpatient group therapy visits	$5 per visit
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission

Home Health Services	You Pay
Home health care (up to 100 two-hour visits per calendar year)	No charge

Other	You Pay
Hearing aid(s) every 36 months	Amount in excess of $1,000 Allowance per aid
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).